The Health of New Hampshire's Community Hospital System

A Financial Analysis

Catholic Medical Center




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An Important Message to Readers of the Hospital Financial Analysis from the New Hampshire Department of Health and Human Services

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Introduction

The following Hospital Financial Analysis is a byproduct of the December 13 report, *The Health of New Hampshire's Community Hospital System*, issued by the New Hampshire Department of Health and Human Services. The individual financial narratives are part of a series of analyses addressing the financial condition of the state's health care system.

In the following report, you will find an analysis of the hospital's financial well being from 1993-1998, and **then an additional analysis** that covers the most recent period for which information is currently available, 1999. As audited financial statements for 2000 become available from the hospitals, this information will be updated.

Each hospital financial analysis is broken into five sections. These include:

- Background information on the hospital size, location, payor mix and affiliates;
- A Summary of the Financial Analysis;
- A Cash Flow Analysis;
- An Analysis of Profitability, Liquidity and Capital; and
- An Estimation of Charity Care and Community Benefits

Financial Benchmarks

Financial benchmarks include traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined below. Additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992).

Profitability:	Purpose	Calculation
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources	Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues	Ratio of Operating Income/Total Operating Revenue
PPS Payment/Cost	Measures the relationship between Medicare PPS payments and Medicare PPS costs; numbers above 1 indicate that payments exceed costs	Ratio of Medicare Prospective Payment System (PPS) Payments /PPS Costs, derived from Medicare Cost Reports
Non-PPS Payment/Cost	Measures the relationship between payment and costs of all payment sources other than Medicare PPS[1]	Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs)
Markup Ratio	Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges	Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense
Deductible Ratio	Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges	Ratio of Contractual Adjustments/Gross Patient Service Revenue
Nonoperating Revenue Contribution	Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit	Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense
Realized Gains to Net Income	Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit	Ratio of realized gains (losses)/Excess Revenue over Expense

[1] Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998

Liquidity:		
Current Ratio	Measures the extent to which current assets are available to meet current liabilities	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers	Patient Accounts Receivable/(Net Patient Service Revenue / 365)
Average Pay Period	Measures how quickly employees and outside vendors are paid by the hospital	(Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses)[2]
Days Cash on Hand	Measures how many days the hospital could continue to operate if no additional cash were collected	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:		
Equity Financing Ratio	Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid)	Unrestricted Net Assets/Total Assets
Cash Flow to Total Debt	Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities	(Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities
Average Age of Plant	Measures the relative age of fixed assets	Accumulated Depreciation/ Depreciation Expense

Hospitals As Integrated Systems of Care

Many of New Hampshire's hospitals have developed into systems of care with complex corporate organizational structures. Hospitals may be owned by a holding company or may themselves own other subsidiaries. (The hospital corporate organization charts will be made available with these financial narratives at a future date.) These individual analyses that follow attempt to isolate the hospital entity to the extent possible as the basis of analysis. This distinction is important because subsidiaries that operate within a larger hospital system may operate at higher or lower levels of financial performance than the hospital. For example, a home health agency impacted by Medicare reimbursement changes that result in an operating deficit might be directly supported by the hospital. On the other hand, an ambulatory surgical unit (or another entity within the holding company of which the hospital is a part of) with a healthy financial performance could have a positive impact on the hospital with an operating deficit.

[2] (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

Charity Care and Community Benefits

Each hospital financial analysis includes a section on Charity Care and Community Benefits. This section of the hospital financial narrative is more exploratory than are the other standardized financial benchmarks. For further background information or for specific information on how these measures were calculated, please see the *Analysis of Health Care Charitable Trusts in the State of New Hampshire.*

In 1999, the legislature passed the New Hampshire Community Benefits law (SB 69), which requires that all non-profit hospitals and other health care charitable trusts with $100,000 or more in their total fund balance complete a needs assessment of the communities that they serve. The legislation also calls for the hospitals and others to consult with members of the public within their communities to discuss what the provider has done in the past to meet community needs, what it plans to do in the future, and then submit the plan to the Attorney General's office.

New Hampshire's law is a reporting statute. It does not contain a dollar value or minimum threshold the non-profit trusts must meet. With this new statute, the hospitals and others are working to improve the measurement of charity care (free care) and other community benefits they provide in return for exemption from local, state and federal taxes. Since this law is relatively new, the audited financial statements used for the purpose of this community benefit analysis may not yet fully reflect the dollar value of community benefits beyond charges foregone for charity care or necessary but unprofitable services. New Hampshire's definition of community benefits is very broad; it includes free care but does not include bad debt or shortfalls in reimbursement from the Medicare and Medicaid programs.

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For More Information

Questions or comment concerning this report may be directed to the Office of Planning and Research at 603-271-5254.

CATHOLIC MEDICAL CENTER, MANCHESTER, NEW HAMPSHIRE 1993 – 1999 FINANCIAL ANALYSIS[3]

Catholic Medical Center (CMC) primarily serves residents of southern New Hampshire (Hillsborough County) and northern Massachusetts. Facilities include 242 acute-care beds[4]. As of 1997, the largest payer is Medicare, representing 57% of all inpatient discharges[5]. Private insurers represent approximately 30% of discharges.

Financial statements represented the hospital only until through 1995, when financial information became consolidated with CMC's wholly owned subsidiary, Physician Practice Associates (PPA), a not-for-profit group of physician practices. The hospital also owns the Regional Cardiac Institute Foundation, though ownership of and accounting method for this subsidiary are unclear. In 1994, Optima Health, Inc., a not-for-profit entity, became the parent corporation of the hospital. As a member of this system, the medical center became affiliated with Elliot Hospital and St. Joseph's Hospital.

Financial Analysis Summary 1993-98

Over the six-year period, CMC generated enough cash from net income and depreciation to cover working capital needs and investing activities without requiring additional long-term borrowing. As a result, CMC decreased outstanding long-term debt and maintained a strong liquidity position due to a strategy emphasizing liquidity over bricks and mortar. The inclusion of PPA, however, contributed to dramatic decreases in profitability between 1995 to 1998, which negatively impacted CMC's financial position. Reduced profitability has triggered some red flags with regard to the hospital's ability to service its long-term debt. However, it has more cash than debt, so it is not in imminent danger of insolvency.

Cash Flow Analysis 1993-98

CMC generated close to 50% of its cumulative cash over the period from net income, and 40% from depreciation. This was adequate to cover investing activities and to make debt principal payments without requiring additional long-term borrowing. CMC prioritized investments in marketable securities and increasing cash reserves, which together represented 60% of cash uses. Investment in property, plant and equipment (PP&E) represented only 23% of total cash uses, and was below cumulative depreciation expense over the period. As a result, the age of plant steadily increased and reached 11.5 years in 1998, making it one of the older hospitals in the state. Working capital was managed well and represented an overall source of cash due to improvements in receivables collections.

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[3] This summary covers the time frame during which Catholic Medical Center was under control of Optima Health, Inc. (as was the other Manchester community hospital, Elliot Hospital). Information contained in an audited financial statement would not reflect the administrative and managerial decisions under which Catholic Medical Center was functioning during this time (e.g., closed services, plans to consolidate services or assignment of system losses). The reader can obtain information on the history of Optima Health, Inc. in the *New Hampshire Attorney General's Report on Optima Health, Inc.* (March 1998) available at: www.state.nh.us/nhdoj/charitable/optima1.html

[4]. 1998 American Hospital Association Guide.

[5] 1997 data from the State of New Hampshire Department of Health and Human Services.

Ratio Analysis 1993-98[6]

Profitability

Profitability was strong prior to 1995, with high and increasing total margins relative to the state median, driven largely by improvements in operating margins. The markup of charges over cost increased and outpaced the growth in deductions from revenue due to payer discounts and contractuals (deductible), which led to the steady increase in operating margins through 1995. After 1995, however, overall profitability declined steadily due to a dramatic decline in the operating margin.

The consolidation with PPA contributed to a sharp drop in profitability, and the operating margin dropped from 9 to 2% between 1995 and 1996. In addition, a 50% increase in management fees to the parent organization contributed to expense growth outpacing revenue growth in 1996. With the addition of two new practices to PPA in 1997, operations broke even and profitability depended on nonoperating revenue, which represented 96% of the total margin in 1997. However, operating losses in 1998 were so large (-11% operating margin) that even the contribution of nonoperating revenues could not produce a positive total margin. The Voluntary Early Retirement Program (VERP) for $4.6 million contributed to 1998 losses.

Realized gains on the sale of investments became increasingly important to net income after 1995; by 1997, realized gains represented approximately one-third of the total margin. Information on realized gains was not available for 1998.

Liquidity

As a result of CMC's liquidity-oriented investment strategy, the current ratio was strong and increased through 1997. Though the current ratio dropped between 1997 and 1998, this measure illustrates that CMC still had enough short-term resources to cover its current obligations three times. The drop in current ratio between 1997 and 1998 is in part due to the large increase in estimated third-party settlement reserves, an estimated current liability account. A more stringent measure of liquidity, the acid test ratio, shows that even after a drop in 1998, CMC still has about twice the amount of highly liquid assets (cash reserves and short-term investments) that it needs to meet current liabilities.

Though 1998 saw a reversal in favorable trends in ratios measuring management of working capital, the overall trend from 1993 to 1998 in these measures remained favorable. Days in accounts receivable decreased steadily from 52 to 46, and cash freed up from faster collections was used pay vendors more quickly, as demonstrated by the decrease in average pay period, from 40 to 32 days.

Days cash on hand with short-term sources is well above the state median and steadily increased until 1997. Again, 1998 saw a decline in this measure, though 75 days cash on hand is generally more than adequate for working capital needs. Days cash on hand including board designated investments also increased steadily until 1998, reflecting CMC's priority on increasing marketable securities and cash reserves. At 192 days cash in 1998, the hospital has maintained strong liquidity.

Capital Structure

At 40% equity financing in 1992, CMC was relatively highly leveraged. The capital structure improved over the period since no new long-term borrowing was incurred. The equity financing ratio increased to 55% (more than half of CMC's assets were financed by equity) as of 1998. A

[6] NH state medians from The 1998-99 Almanac of Hospital Financial & Operating Indicators

decreasing (favorable) long-term debt to equity ratio further supports this, steadily declining from 82 to 41%.

Although these trends are positive overall, there was deterioration in both these solvency measures between 1997 and 1998 due to the drop in profitability. It is also noted that some of the improvement in equity measures is due to equity infusions from a parent organization and a change in accounting principles. These are not generally ongoing sources of new equity. Equity transfers from the parent company in 1996 and 1997 ($500K and $1.9M, respectively) also contributed to the favorable capital structure. An accounting principle change requiring investments to be reported at market value rather than cost also increased the fund balance by unrealized gains after 1996.

While overall capital structure improved over the period, decreased profitability after 1995 caused debt coverage ratios to decline steadily, and large losses in 1998 caused a precipitous drop. Though the debt service coverage ratio steadily declined after 1995, CMC was still able to cover its principal and interest payments with a large margin of safety through 1997. In 1998, however, this ratio dropped to 0.3, indicating that CMC did not generate enough cash from operations to cover its debt service. Without nonoperating revenues, CMC would not have had enough cash from operations to service its debt payment.

Cash flow to total debt, which decreased by half after 1995, is worrisome. This measure dropped to 18% in 1997, in the lowest 10^{th} percentile in the state, and was only 9% when only operating income is considered. By 1998, cash flow from operations could not even cover 1% of the total debt. This is a red flag that CMC may have trouble servicing its debt if losses continue.

Charity Care and Community Benefits

As measured by charges forgone, the amount of charity care as a percentage of gross patient service revenue declined from 5 to 3% over the period. This amount was generally less than half the estimated value of CMC's tax exemption, but with the inclusion of 50% bad debt, the amount of charity care provided generally met the tax value.

CMC reported additional quantifiable charity care in the form of community service programs for which it receives no payment, such as Prime Time, Center for Healthy Aging, Prenatal Clinic Care and Ask-a-Nurse. The cumulative amount spent on these programs was $11.6 million over 1993 - 1998. Additionally, CMC donated $2.3 million to Manchester Community Health Center, which it helped found, and Child Health Services. With these amounts added to free care, free care met the estimated value of the hospital's tax exemption in all years except 1994 and 1995, when 50% bad debt was still needed to meet this benchmark.

CMC also provides HIV/AIDS services[1], which may be considered an additional community benefit.

Cash Flow Analysis 1993 - 1999

From 1993 to 1999, Catholic Medical Center (CMC) generated more than 35% of its cumulative cash from net income and 44% from depreciation. This was adequate to cover investing activities and to make debt principal payments without requiring additional long-term borrowing. CMC investments in marketable securities and cash reserves represented 60% of cash uses. Investment in property, plant, and equipment represented 27% of total cash uses. This was less than cumulative depreciation expense over the period. As a result, the age of plant steadily increased and reached 10.81 years in 1999, making it one of the older hospitals in the state (according to the hospital…"However, a recent analysis of the building indicates no life safety issue."). Working capital was managed well and represented an overall source of cash due to improvements in accounts receivable collections.

1999 Ratio Analysis

Profitability

The operating margin in 1999 was -10%, and the total margin was -5%. A large positive non-operating revenue contribution brought the total margin to –5%. Realized gains on the sales of investment have also dropped from 43% of net non-operating revenue in 1998 to 20% of net non-operating revenue in 1999.

The operating loss improved slightly due to a 7% reduction in operation expense, while operating revenue went down by 6%. The reduction in operating expenses was due to the reduction of supplies and other expenses of $4.9 million, which represented 50% of the total reduction. In addition, the voluntary early retirement plan offered by Optima in June 1998 reduced the pension expenses by $5 million. This constituted another 50% of the 7% operating expense reduction.

Liquidity

CMC's acid test ratio dropped from 1.8 to .99 in 1999. The current ratio dropped slightly from 6.08 in 1998 to 5.24 in 1999. The average days of accounts payable increased from 31.68 days in 1998 to 34.55 days in 1999. Days of cash on hand with short-term sources in 1999 was 49 days (a decrease from 75 days in 1998). However, days of cash on hand including board-designated investments increased from 192 days in 1998 to 199 days in 1999. In 1999, the hospital was strong and liquid.

Capital Structure

The long-term debt to equity ratio increased from 41% in 1998 to 43% in 1999. This was due to the drop in profitability since 1997. In 1999, debt service coverage ratio was 0.13. The cash flow to total debt is –0.03. The ratios indicate CMC may have to draw down on its cash reserves to service debt, if operating losses continue.

Charity Care and Community Benefits

The amount of charity care as a percentage of gross patient service has maintained at a consistent ratio since 1997, around 1%.

CMC provided $2.1 million for community service programs such as *Primetime*, *The Center for Healthy Aging*, pre-natal clinical care, and *Ask a Nurse*. In addition, the Medical Center provided $312,000 in community service to the Manchester community.

Summary

CMC's operating profitability has declined significantly in both 1998 and 1999, which negatively affects its solvency ratios. Poor performance of physician practice associates contributed to this loss. However, the hospital had significant cash reserves that protected it from any immediate dangers of insolvency.

Source: Audited Financial Statements. Prepared by Nancy M. Kane, D.B.A. Harvard School of Public Health